

STATE OF INDIANA State Personnel Department, Benefits Division Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)

PO Box 40968 Indianapolis, IN 46240

Telephone: (317) 574-7876 or (888) 818-7795

Fax: 317-574-7865

Carefully read the following options. Please check the option that you wish to use. You may change your option at any time during the disability. The options can only be changed with the completion of a new Options Statement. The effective date for the change in options will be the date the new Options Statement is received by JWF Specialty Co., Inc. The change in options will only apply to future After the 30 day Elimination Period I elect: □OPTION 1: BASIC DISABILITY BENEFITS 60% of regular biweekly salary while on Short Term Disability or see below* □OPTION 2: INCREASED DISABILITY BENEFITS May choose to receive 20% more than the basic benefit by using a prorated charge against accrued leave balance. * Please indicate the order in which these days are to be used: SICK PERSONAL VACATION ____COMPENSATORY Special Sick Leave may be used once all other leave balances have been exhausted. Do you wish to use Special Sick Leave? ☐Yes ☐No ☐ OPTION 3: USE OF ACCRUED LEAVE 100% of regular biweekly salary by choosing to use your vacation, sick, personal, compensatory, or special sick leave at the rate of 5 days per week in lieu of disability benefits. This option pays NO disability benefits. You will be paid by your agency** Please indicate the order in which these days are to be used: SICK PERSONAL VACATION COMPENSATORY Special Sick Leave may be used once all other leave balances have been exhausted. Do you wish to use Special Sick Leave? □Yes □No *Short Term Disability benefits may not exceed five months. Long Term Disability benefits are 50% for the first 2 years, 40% for third and fourth years. ** Once all leave is exhausted, you are automatically eligible for OPTION 1, provided all other requirements are met. If you were injured on the job and wish to increase your Workers' Compensation benefits by using your accrued leave, CONTACT YOUR AGENCY. Signature of employee Date signed (month, day, year) Signature of witness Date signed (month, day, year)